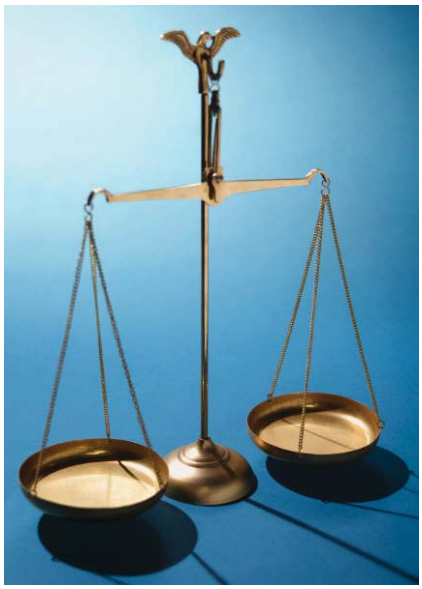
Payment & Reimbursement At A Glance

A Guide to Receiving Financial Assistance



South Carolina
State Office of Victim Assistance

SOVA

SOVA
SOUTH CAROLINA
State Office of Victim Assistance
Rooted in *justice*
Guided by *law*
Propelled by *humanity*

2012 Edition

SOVA
Office of the Governor, State Office of Victim Assistance, 1205 Pendleton Street, Rm. 401, Columbia, SC 29201
Phone (803) 734-1900 | Victims Only Please 1-800-220-5370 | www.sova.sc.gov

A Guide to Receiving Financial Assistance from SOVA

PART ONE:
COMPENSATION PROGRAM (Eligibility Criteria)

PART TWO:
SAP/CAP PROGRAM (Eligibility Criteria)
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Disclaimers

This PDF has been designed to help you navigate your way through our Payment and Reimbursement process. In preparation of this material, every effort has been made to offer the most current, correct, and clearly expressed information possible. However, this information is for general purposes only. While SOVA makes every effort to provide accurate and updated material for you; periodically, data may change prior to any updates and revisions. Therefore, you are encouraged to contact our office if you have any questions.

This material is not provided as a guarantee for payment or pre-approval for services. SOVA is providing this information in an effort to decrease the turn-a-round time for processing claims. All claims or applications for assistance must meet the eligibility criteria prior to consideration with crime related compensable expenses. Victims/claimants are encouraged to provide this agency with the appropriate documentation for reimbursement and payment consideration.

Forms:
Any information submitted on the forms is fictitious and intended for sample purposes only. Actual forms will reflect real data entered by providers. This material also includes forms from organizations other than SOVA and has been provided for sample purposes only.

Victim's privacy:
To protect victim/claimant's privacy, SOVA will not provide information to family or friends without prior authorization from the victims/claimants in writing.

Pre-existing conditions:
If you have a pre-existing medical/dental condition (a condition that existed prior to the crime), you could be required to provide the agency with a Certificate of Clinical/Dental Necessity from your treating physician/clinician/dentist certifying that your treatment is directly related to the crime on which the claim is based and that the expenses incurred as a result of your treatment are crime related.

Victims' Responsibilities

Important Information for Advocates, Providers and Victims

Payer of Last Resort:
SOVA is an assistance program. All submitted compensable expenses will be offset by other available sources before reimbursements/payments are considered. Victims will be required to file all compensable expenses with his/her private or public health insurance company/carrier first, this includes Medicaid and Medicare. Victims' compensable expenses are also offset by restitution, subrogation or civil settlements. Because SOVA is not a guarantor for crime victims compensable expenses, providers are encouraged to mail all bills to victims and forward UBs/HCFAs etc. to SOVA.

Change of address for victims/claimants:
To ensure timely payments/reimbursements or to avoid interruptions of lost wages, the victims/claimants will be required to provide SOVA with change of address and telephone number.

Victim Compensation Code of Laws

Visit: **http://www.scstatehouse.net/code/t16c003.htm**
Title 16, Chapter 3, Section 16-3-1110 * 16-3-1420
for a complete listing of the laws.

Collection Activity:
Section 16 3 1360: Collection activities prohibited
When a person files a claim pursuant to this article, a health care provider that has received written notice of a pending claim is prohibited from all debt collection activities relating to medical and psychological treatment received by the person in connection with the claim until an award is made on the claim or the claim is determined to be non-compensable and is denied, or ninety days have passed after the health care provider first received notice of a pending claim.

$100.00 Threshold:
Section 16-3-1180(D) An award may be made only if and to the extent that the amount of compensable loss exceeds one hundred dollars; however, this limitation may be waived in the interest of justice and must be waived upon a showing that the claimant is at least sixty-five years old.

Claims inactive for more than 18 months:
Section 16-3-1180(E) A previously decided award may be reopened for the purpose of increasing the compensation previously awarded. The State Office of Victim Assistance shall send immediately to the claimant a copy of the notice changing the award. This review may not be made after eighteen months from the date of the last payment of compensation pursuant to an award under this article unless the director determines there is a need to reopen the case as specified in Section 16-3-1120(4).

PART ONE:

COMPENSATION PROGRAM

SOVA has a four (4) step payment process

Step 1
The Intake Process
You will receive a letter in the mail confirming that your application has been received.

Step 2
The Eligibility Process
If your claim is eligible, you will receive an eligibility letter. If your claim is denied, you will receive a denial packet.

Step 3
The Restitution/Subrogation Process
If your claim meets the eligibility criteria, you will receive a letter regarding your responsibility when restitution is ordered by the court or if you receive a settlement from other insurance.

Step 4
The Payment & Reimbursement Process
Your crime related bills and expenses will be processed for payments to your providers and /reimbursements to you.

For eligible claims (bills/expenses): SOVA will begin to process your payment in step 4. To assist with Step 4, please review the Payment & Reimbursement At-A- Glance sheet.

You may begin to contact your Doctor, Dentist, Counselor, or the Hospital and request that a medical/dental claim form be faxed to the agency at (803) 734-2261. After you receive your Notice of Award letter, allow 4 to 6 weeks for payments.

Crime Related Expenses (For Medical/Dental/ Eyeglasses)

Medical

Victims must submit the following forms for his/her crime related medical expenses to be considered for payments/reimbursements:

One of the following forms will be required for all separate crime related dates of service.
The victim will have to contact his/her provider (provider can mail or fax the medical claim forms).

- UB-04 Medical Claim Form
- UB-92 Medical Claim Form
- Health Insurance Medical Claim Form (CMS-1500) (HCFA-1500)
- Itemized bill of Charges from your medical provider
- Health insurance information (EOB Explanation Of Benefits)

When the victim has health insurance coverage, he/she will be required to provide information (EOB) for all crime related dates of service.

- Explanation of Benefits from the Health Insurance Company or provider (EOB) (See the EOB section on this site for additional information.)
- Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are required to provide providers with health insurance information.

Dental

Victims must submit the following forms for his/her crime related dental expenses to be considered for payments/ reimbursements:

One of the following forms will be required for all separate crime related dates of service.
The victim will have to contact his/her provider (provider can mail or fax the dental claim forms).

- Itemized bill of Charges from your provider
- ADA Dental Claim Form (w/treatment plan)
- Health insurance information (EOB Explanation Of Benefits)

When the victim has dental insurance coverage, he/she will be required to provide information (EOB) for all crime related dates of service.

- Explanation of Benefits from the Health Insurance Company or provider (EOB) (See the EOB section on this site for additional information.)
- Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are required to provide providers with health insurance information.

Eyeglasses

Replacement or purchase of eyeglasses is a compensable expense when:

- It is found that the victim's glasses were broken or damaged during the incident;
- The damaged/broken glasses were reported to law enforcement;
- The information is in a police report or supplemental report;
- A detailed bill from your chosen vision center is submitted.

OR

- The injury was reported to law enforcement;
- The victim's vision is impaired as a direct result of the crime;
- Medical documentation supports that the glasses are medically necessary;
- A detailed bill from your chosen vision center is submitted.

Note: SOVA will pay a maximum of $125.00 for eyeglass frames. Lenses are covered in full according to the prescription when it is found to be medically necessary. Warranties are not a covered expense.

Crime Related Funeral Expenses

Claimants must submit the following forms/documents for the crime related funeral expenses to be considered for payments/reimbursements:

- Death Certificate
- Itemized bill/contract (The bill must include the service provider's name and remit address.)

The person who is responsible for the funeral expenses incurred may file for reimbursement relating to the cost of the funeral. The responsible party is the person(s) who signed the contract or who paid the funeral bill.

Compensable Medical Expenses:

- **If** the **deceased victim** was an **adult**, the victim's spouse may file for any compensable medical expenses that he/she may have incurred.
- **If** the **deceased victim** was a **minor** child, the parent may file for any compensable medical expenses he/she may have incurred.
- **If** the **deceased victim was not married** or **if the deceased victim was not a minor child** at the time of the crime, SOVA will only consider the compensable funeral expenses.

Crime Related Counseling Expenses

Victims must submit the following forms for his/her crime related counseling expenses to be considered for payments/reimbursements:

- SOVA Mental Health Counselor's Report
- Itemized bill of Charges w/CPT codes or,
- Health Insurance Medical Claim Form (CMS/HCFA-1500)
- Explanation of Benefits (EOB) for each date of service

Information about his/her medical insurance coverage:

(When the victim has health insurance coverage, he/she will be required to provide information for all crime related dates of service.)

- Explanation of Benefits (EOB) from the health insurance company or provider

- Information for providers

Health and Dental Insurance Explanation of Benefits (EOB)

How much did your health plan pay? How much do you owe?

Because SOVA is a payer of last resort, when the victim has health or dental insurance coverage (public or private) he/she will be required to provide SOVA with an Explanation of Benefits (EOB) from the Health or Dental Insurance Company or provider for all crime related dates of service.

Pursuant to public and private health insurance guidelines regarding timely filing and pre-authorization, victims are encouraged to provide providers with health and dental insurance information at the time of each visit.

- **EOB is a statement sent to you, the member, and your provider once a claim has been processed on your behalf. The EOB includes information about the services provided, eligible expenses and amount paid. If the claim was denied, it will also contain information about why this occurred.**

- **The EOB includes details about the services, provider, the date of the service, amount allowed, amount paid, cost sharing details, member liability, denial reasons, and appeal rights.**

IMPORTANT INFORMATION:

SOVA will pay the balance due after health/dental insurance.

CRIME RELATED "Out of pocket expenses" for

Prescription Drugs

Victims must submit the following information for his/her crime related "out of pocket expenses" to be considered for reimbursement:

Only one of the following will be required (Some victims will have to provide additional information from his/her treating physician)

- Copy of receipt from the pharmacy (*receipt must have* - patient's name, date, total charge, name of medication, RX (prescription) number, name of the pharmacy & name of the doctor) or
- Print out of 'patient history' from the pharmacy

Crime Related
"Out of pocket expenses"

Mileage For Transportation To And From Medical/Dental/Counseling Appointments

Victims must submit the following information to be considered for reimbursement for his/her expenses relating to transportation to and from appointments:

MILEAGE: What will be required?

- A written request from the victim/claimant
- List of appointments for which you are requesting consideration for mileage
- Medical claim forms/itemized bills for each appointment

IMPORTANT NOTE:

- **Medical/dental/counseling medical claim forms/itemized bills are used to confirm appointments;**
- **The distance between the victim/claimant's home (must provide physical address) and the medical/dental/counseling facility must be 5 miles or more (one way) before SOVA will consider reimbursement for mileage;**
- **The request for mileage should be submitted in writing (the victim will need to provide the date of the visit, service type and location; this is corroborated with compensable itemized bills).**

One of the following will be required for each appointment date:

- UB-04 Medical Claim Form
- UB-92 Medical Claim Form
- Health Insurance Medical Claim Form (CMS-1500) or (HCFA-1500)
- Itemized Statement of Charges
- ADA Dental Claim Form (w/treatment plan)

The following are non-covered expenses:

- Mileage for court appearances
- Mileage for meetings with law enforcements
- Mileage for meetings with Solicitors
- Mileage for Medicaid and Medicare recipients

Crime Related
Lost Wages

CRITERIA: (all four criteria must be met)

1) Employed: The victim must have been employed at the time of the crime;
2) Missed time from work: The victim must have missed two (2) consecutive weeks from work as a direct result of the crime;
3) Reportable income: Reimbursement is based on reportable income; and
4) Disabled: The victim must be under the care of a treating physician.

LOST WAGES: (The victim must have been employed at the time of the crime and missed two consecutive weeks from work as prescribed by the treating physician.)

Victims must submit the following information for his/her crime related lost wages to be considered for reimbursement:

- SOVA Employer's Report
- SOVA Physician's Disability Report
- Copy of your last two pay stubs prior to the incident
- Other documentation may be required for individuals who are self-employed (See the 'Self Employed' section for additional information)

MOST FREQUENTLY ASKED QUESTIONS:

How is the compensation rate determined?

- SOVA calculate lost wages at the rate of 66 2/3 percent of your average weekly wage not to exceed the maximum weekly compensation rate for the year of the crime. If you were working two or more jobs at the time of crime, those wages will be included as part of the average weekly wage and compensation rate.

For crimes that occur on or after January 1, 2012	For crimes that occur on or after January 1, 2011	For crimes that occur on or after January 1, 2010
the maximum weekly compensation rate is $ 725.47	the maximum weekly compensation rate is $704.92	the maximum weekly compensation rate is $689.71

When are my benefits terminated?

- Payment for lost wages can be made until you either return to work full-time, part-time, the disability period given by the doctor ends, or the maximum award allowed is reached.

Will SOVA contact my Treating Physician(s) or my Employer(s)?

- SOVA will contact Treating physicians and Employers to verify information.

Can I receive lost wages if I am receiving short term disability from my job?

- Lost wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.

Self Employed

CRITERIA: (All four criteria must be met)
1)The victim must have been employed at the time of the crime;
2)The victim must have missed two (2) consecutive weeks from work (as a direct result of the crime) and was not compensated with annual/sick leave or short/long term disability;
3)Reimbursement is based on reportable income; the victim must be able to provide proof of reportable income; and
4)The victim must be under the care of a treating physician as a direct result of the injury sustained during the incident. The treating physician must be willing to provide a written document certifying the victim's disability.

This section applies to you:

- If you were self employed at the time of the crime,
- If you received your earnings in cash, personal checks or money order,
- If you received your earnings in tips,

- Then you will need to provide Proof of Reportable Income.

Your tax return transcript from the IRS is considered "Proof of Reportable Income".

You can order your tax return transcript(s) using the IRS new Order a Transcript self-service transcript order line at 1-800-908-9946. Instructions are listed below:

1-800-908-9946, then
Select option 1 for English, then
Enter your SS#, then
Select 1 to confirm your SS#, then
Enter your house or apartment number,
You will be provided with instructions, then
Select option 2 to order your transcript, then
Enter the year for the tax return you are ordering - i.e. 2010; 2009; 2007, then
Select option 1 to confirm the year for the tax return that you are ordering,
After the prompt, if your information is correct select option 1, finally
Select option 3 to complete your order

There are no fees for the tax return transcript. You can expect to receive your transcript within 5 to 10 days from your order date.

NOTE: Wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.
NOTE: For long term lost wages, with written permission from the victim, SOVA will consider WAGES ONLY.
The victim will assume the responsibility for other compensable expenses.

PART TWO:

SAP/CAP PROGRAM

Sexual Assault Protocol (SAP)
Child Physical Assault Protocol (CAP)

Eligibility Criteria

SAP/CAP PROGRAM: (Pursuant to SECTION 16-3-1350 - SOVA is the primary payer, victims/claimants are not to be billed).

- A crime occurred in South Carolina

Sexual Assault (Acute) Protocols: (Victims 18 and older)
- SLED approved protocol kit must be used

Anonymous Reporting: Sexual Assault (Acute) Protocols (Victims 18 and older)
SLED approved protocol kit must be used: when providing law enforcement information –write in “Anonymous” instead of the name of the law enforcement agency: To establish that the crime happened in SC or incident jurisdiction: provide the county and state.

Sexual Assault (Chronic) Protocols: (Victims 17 and younger or vulnerable adults)
- South Carolina Children’s Advocacy Medical Response System Child Maltreatment Protocol must be used http://www.sccamrs.org
- The crime was reported to law enforcement

Forensic Interviews: (Victims 17 and younger or vulnerable adults)
- The forensic interview was performed using the standards defined by SOVA
- The crime was reported to law enforcement

SECTION 16-3-1350. Medicolegal examinations for victims of criminal sexual conduct or child sex abuse. [SC ST SEC 16-3-1350]

(A) The State must ensure that a victim of criminal sexual conduct in any degree, criminal sexual conduct with a minor in any degree, or child sexual abuse must not bear the cost of his or her routine medicolegal exam following the assault.

(B) These exams must be standardized relevant to medical treatment and to gathering evidence from the body of the victim and must be based on and meet minimum standards for rape exam protocol as developed by the South Carolina Law Enforcement Division, the South Carolina Hospital Association, and the Governor's Office Division of Victim Assistance with production costs to be paid from funds appropriated for the Victim's Compensation Fund. These exams must include treatment for sexually transmitted diseases, and must include medication for pregnancy prevention if indicated and if desired. The South Carolina Law Enforcement Division must distribute these exam kits to any licensed health care facility providing sexual assault exams. When dealing with a victim of criminal sexual assault, the law enforcement agency immediately must transport the victim to the nearest licensed health care facility which performs sexual assault exams. A health care facility providing sexual assault exams must use the standardized protocol described in this subsection.

(C) A licensed health care facility, upon completion of a routine sexual assault exam as described in subsection (B) performed on a victim of criminal sexual conduct in any degree, criminal sexual conduct with a minor in any degree, or child sexual abuse, may file a claim for reimbursement directly to the South Carolina Crime Victim's Compensation Fund if the offense occurred in South Carolina. The South Carolina Crime Victim's Compensation Fund must develop procedures for health care facilities to follow when filing a claim with respect to the privacy of the victim. Health care facility personnel must obtain information necessary for the claim at the time of the exam, if possible. The South Carolina Crime Victim's Compensation Fund must reimburse eligible health care facilities directly.

(D) The Governor's Office Division of Victim Assistance must utilize existing funds appropriated from the general fund for the purpose of compensating licensed health care facilities for the cost of routine medical exams for sexual assault victims as described above. When the director determines that projected reimbursements in a fiscal year provided in this section exceed funds appropriated for payment of these reimbursements, he must direct the payment of the additional services from the Victim's Compensation Fund. For the purpose of this particular exam, the one hundred dollar deductible is waived for award eligibility under the fund. The South Carolina Victim's Compensation Fund must develop appropriate guidelines and procedures and distribute them to law enforcement agencies and appropriate health care facilities.

Billing Fact Sheet

Sexual Assault Forensic Medical Examination – 18 and older

Pursuant to SC Code Section 16-3-1350, which follows the guidance of the federal Violence Against Women Act statute, victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. Health Care Providers will bill SOVA directly for individual charges for lab work, emergency room fee, physician's fee, etc. **Neither the victim nor their insurance, including Medicaid and Medicare, may be billed for the medicolegal examination.** Any fees beyond the actual collection of any evidence during a forensic examination will be the responsibility of the victim. Should law enforcement be involved, the option of SOVA victim compensation reimbursement becomes available.

Payment for a routine medicolegal examination of any alleged victim of assault in any degree is dependent upon the following criteria/conditions:

- The assault must have occurred in South Carolina
- SLED approved Sexual Assault Protocol kit must be used;
- SOVA Sexual Assault Protocol (SAP) Billing Statement must be submitted;
- SOVA Medical Examination Release Form must be submitted: NOTE: **For Anonymous Reporting: when providing law enforcement information, write in 'ANONYMOUS' instead of the name of law enforcement agency. To establish that the crime/incident occurred in SC, the incident location (county and state) will be required.**

The medical examination release form and the SOVA billing statement found in the evidence collection kit must be completed and submitted to the State Office of Victim Assistance providing the following:

- name, address and signature of victim
- name and address of the health care facility
- when the incident was reported to law enforcement: name of law enforcement agency taking report
- Incident location (county and state)

No payment will be made unless forms are completed and submitted with correct documentation within 180 days from the date of the exam.

This Program is not permitted to pay for additional procedures such as:

- surgery, hospital admission, follow-up counseling, x-rays, **follow-up examinations**, treatment, blood work, alcohol or drug screens, or testing, stat charges, etc.

[Victims of assault who incur charges not covered under the Sexual Assault Protocol Program may submit a Victim Compensation application for payment consideration to the Victims' Compensation Fund.]

The Protocol Program makes payments to health care providers on a monthly basis. When multiple claims are submitted from a single provider for payment, one check is issued and sent with a list showing victims covered by payment.

Fact Sheet

Forensic Interviews

The State Office of Victim Assistance (SOVA) is authorized by state law (SC CODE SEC 16-3-1350) to pay for allowable charges incurred in gathering evidence from a victim at law enforcement's request. The forensic interviewer must be a master's level licensed mental health professional and have participated in at least one forty-hour specialized forensic interviewer training provided through the American Prosecutor's Research Institute (APRI) Finding Words, the National Children's Advocacy Center (NCAC), or the American Professional Society on the Abuse of Children (APSAC). If not licensed, the forensic interviewer must be supervised by a licensed mental health professional, i.e. LMSW, LISW, LMFT, or LPC. Anyone supervising an unlicensed interviewer must provide a copy of their license. The unlicensed interviewer must be working towards a license. Once licensed the interviewer must provide a copy of their license.

To receive reimbursement for performing a forensic interview, the interviews must be conducted at a facility that follows the multi-disciplinary model; a billing invoice for services rendered as well as a summary of the findings must be submitted and signed by the service provider. Providers must have previously been approved by SOVA. Victims or their insurance must not be billed for these services.

In addition, a release form must be completed and submitted along with the billing invoice and summary of findings. This release must include:

1. Victim's name, address and signature of the victim/guardian;
2. Name, credentials and signature of the forensic interviewer;
3. Name and address of the provider;
4. Location of crime and name of the law enforcement agency that took the report;
5. Name of the investigating/reporting officer (and signature, if available).

Payment for a forensic interview of a child alleged to be the victim of physical or sexual assault is contingent upon the following conditions:

1. The crime must have occurred in South Carolina.
2. The victim or guardian must file an incident report with law enforcement.
3. The forensic interview must be ordered by law enforcement.
4. The forensic interview must be performed using the standards defined by SOVA.

A law enforcement incident report that names each child as a victim is required along with the billing information.

This forensic interview reimbursement program cannot pay for additional procedures such as psychological testing/evaluation or mental health treatment. Victims who incur other crime related medical or mental health bills may submit a separate Crime Victim's Compensation application to SOVA. The application will be reviewed for eligibility for certain benefits including mental health counseling. A victim must file with his or her health insurance first for other incurred expenses. SOVA will consider balances due for mental health treatment after payment by individual insurance.

(SAP) Sexual Assault (Acute) Protocol -Anonymous Reporting

Victims 18 and older

Criteria

- SC CODE SECTION 16-3-1350
- Eligibility Criteria

Payment Requirements

- Billing Fact Sheet
- SLED approved Sexual Assault Protocol kit must be used
- SOVA Sexual Assault Protocol (SAP) Billing Statement (located in SLED approved kit)
- SOVA Medical Examination Release Form (located in the SLED approved kit)
- Payment requested within 180 days from the date of service

Important

SOVA Medical Examination Release Form must be submitted with the following information:

- The name of the Law Enforcement Agency; for Anonymous Report, when providing law enforcement information, write in 'ANONYMOUS' instead of the name of the Law Enforcement Agency.
- To establish that the crime happened in SC: the incident location (city/county and state) will be required.

SCP - Sexual Assault (Chronic) Protocol

(Evidence collected after 72 hours from the date of the crime)

Criteria

- SC CODE SECTION 16-3-1350
- Eligibility Criteria

Payment Requirements

- South Carolina Child Advocacy Medical Response System Protocol kit must be used
- http://www.sccamrs.org

- Complete and submit pages 1 and 2 of the Child Maltreatment Protocol billing statement
- Submit Child Maltreatment Protocol Authorization and Release Form located in the Child Maltreatment Protocol
- Law enforcement incident report (listing child as a victim)
- Payment requested within 180 days from the date of service

FIP - Forensic Interview Protocol

Criteria

- SC CODE SECTION 16-3-1350
- Forensic Interview Fact Sheet
- Eligibility Criteria

Payment Requirements

- Submit billing invoice
- SOVA forensic interview release form
- SOVA forensic interview report form and
- Law enforcement incident report (listing child as a victim)
- Payment requested within 180 days from the date of service

Standards

- The interview must be performed using standards defined by SOVA.
- Interviews must be conducted at a facility that follows a multi-disciplinary model.
- Interviewer must have a Masters level degree and must be licensed.
- If not licensed, the interviewer must be working towards a license and must be supervised by a licensed mental health professional.

NOTE: The forensic interview reimbursement program will pay $175.00 for the interview.

PART THREE:
PAYMENTS & REIMBURSEMENTS "AT A GLANCE"

<u>Who may file</u> a "Crime Victim's Compensation Application" with SOVA?

<u>The Direct Victim:</u> The victim who sustained the injury or the victim who died as a direct result of the crime related injury sustained.

<u>The Indirect Victim</u>: Crime Type Specific

The Direct Victims' Spouse: Consideration for Counseling Expenses

The Direct Victims' Children: Consideration for Counseling Expenses

The Direct Victims' Parents: Consideration for Counseling Expenses

The Direct Victims' Siblings: Consideration for Counseling Expenses

<u>An application must be submitted for each person filing for compensation.</u>

A claim/application must be submitted for the direct victim first before consideration will be given to the indirect victim's claim/application.

Benefits for the indirect victim (spouses, children, parents, and siblings) are contingent upon the eligibility status of the direct victim's claim: If the direct victim's claim is eligible, the indirect victim's claim could be deemed eligible. If the direct victim's claim is ineligible, the indirect victim's claim could be deemed ineligible.

State Office of Victim Assistance
Compensation & Sexual Assault Programs at a Glance...

Compensation Program:
An Assistance Program;
Payer of Last Resort
SECTION 16-3-1180 & 16-3-1360

Medical/Dental/Optical Expenses
*Must provide: UB04/UB92/CMS 1500 medical claim form/itemized bill or ADA dental claim form along with EOB for each date of service

Funeral Expenses
*$4,000 maximum allowed
Taken from the total award

Counseling
*20 sessions/180 days
*Effective 1/1/09, victims may be eligible for additional sessions

Prescription Drugs
*Must submit a copy of the paid bill from the pharmacy

Mileage
*Medical/Counseling/Dental Appointments only
Compensable bills are used to confirm compensation

Lost Wages
*Must have missed 2 consecutive weeks from work as prescribed by treating physician; *NOTE: Wages will be offset by other resources such as annual or sick leave, long/short term disability, SSA/SSI.*

Sexual Assault Program:
Evidence Collection:
SECTION 16-3-1350

Sexual Assault Acute Protocol
*Evidence collected within 120 hours of the assault

Anonymous Reporting
Sexual Assault Acute Protocol
*Evidence collected within 120 hours of the assault – for victims 18 and **older**

Sexual Assault Chronic Protocol
*Evidence collected after 72 hours of the assault (**www.sccamrs.org**)

Forensic Interviews
*Interview ordered by Law Enforcement
$175.00 one-time fee

For all medical treatment as a result of physical injuries sustained during the assault, and for follow-up appointments, *A victim compensation application will be required*

Compensation Program
All reimbursements are subtracted from the $15,000 maximum award amount. The victim may be eligible for additional financial assistance upon showing of a financial need.

Compensation Program:

Payment & Reimbursement At A Glance

IF: You are requesting assistance with	THEN: You will need to provide
Crime Related Medical/Dental/Optical Expenses For payments to the providers or reimbursements to victims: one or more of the following will be required for all separate crime related dates of service. SOVA pays the outstanding balance for compensable bills not fully covered by existing medical/dental insurance. If a victim has private or public medical/dental insurance, bills must first be filed with applicable companies/carriers before submission to SOVA for possible payment/reimbursement. *NOTE: SOVA pays after health and dental insurance*	• UB-04 Medical Claim Form (from your provider) • UB-92 Medical Claim Form (from your provider) • Health Insurance Medical Claim form (CMS-1500) (HCFA-1500) (from your provider) • Itemized bill of charges from medical provider • ADA Dental Claim Form (w/treatment plan) (certificate of dental necessity might be required) • Itemized bill from vision center for eyeglasses • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insurance) When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
Crime Related Counseling Expenses SOVA provides reimbursement for trauma (generally considered as a medical expense) only when such service is rendered by a professional who is licensed in a specialty which includes mental health counseling; this includes LMSW (when not practicing independently) LPC, LMFT, LCSW, LISW, Psychiatrist, Psychologist, and MD. For payments to the provider or reimbursements to victims: one or more of the following will be required for all separate crime related dates of service. NOTE: SOVA pays after health insurance.	• SOVA Mental Health Counselor's Report • Itemized Statement of Charges w/CPT codes, or • Health Insurance Claim Form (CMS/HCFA-1500), (Providers can fax a copy to SOVA) • EOB (Explanation of Benefit from Health/Dental insurance company)(Health/Dental/Medicaid must be filed first if a victim has private or public insurance): When the victim has Health/Dental/Medicaid Insurance coverage, he/she will have to provide information for all crime related dates of service.
Crime Related Expenses for Medication For reimbursements to victims: one or more of the following will be required: (Some victims will have to provide additional information from his/her treating physician if the medication appears to be for a pre-existing condition or non crime related condition.) NOTE: SOVA pays after health insurance.	• Copy of receipt from the pharmacy (*receipt must have* - patient's name, date, total charge, name of medication, RX number, name of the pharmacy & name of the doctor) or • Print out of 'patient history' from the pharmacy
Crime Related Funeral Expenses The person who is responsible for the funeral expenses incurred may file for reimbursement relating to the cost of the funeral. That will be the person(s) who signed the contract or who paid the funeral bill. If the deceased victim was an adult, the victim's spouse may file for any compensable medical expenses that he/she may have incurred. If the deceased victim was a minor child, the parent may file for any compensable medical expenses he/she may have incurred.	• Death Certificate • Itemized bill/contract (* bill must include service provider's name and remit address)

Payment & Reimbursement At A Glance (continued)

IF: You are requesting assistance with	THEN: You will need to provide
Crime Related Lost Wages The following 4 (four) criteria must be met: 1. Employment: The victim must have been employed at the time of the crime, 2. Missed time from work: The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. Reportable income: Reimbursement is based on reportable income, and 4. Disabled: The victim must be under the care of a treating physician.	The following documents must be submitted • SOVA Employer's Report • SOVA Physician's Disability Report • Copy of your last two pay stubs (prior to the crime date). *NOTE: Wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.*
Crime Related Lost Wages (You were self employed at the time of the crime) 1. Employment: The victim must have been employed at the time of the crime, 2. Missed time from work: The victim must have missed two (2) consecutive weeks (14 days) from work as a direct result of the crime, 3. Reportable income: Reimbursement is based on reportable income, and 4. Disabled: The victim must be under the care of a treating physician. *NOTE: Wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.*	1) Disability: • SOVA Physician's Disability Report (will be required to establish disability and length of disability) 2) Employment: One or more of the following will be required: (to establish employment) • SOVA Employer's Report, and/or • 1099, (prior year form will be used for short term reimbursements) (lost wages are calculated using information for the year of the crime) and/or • W-2 (prior year form will be used for short term reimbursements) (lost wages are calculated using information for the year of the crime). 3) Reportable Income: (lost wages are calculated using information for the year of the crime) • 1040 US Individual Income Tax Return (prior year form will be used for short term reimbursements), • Schedule SE (Form 1040) Self – Employment Tax Form, • Form 4070 – Employee's Report of Tips to Employer.
Important Information The following are forms/documents that are UNPROCESSABLE and can not be accepted	**Unprocessable Forms** • Final Notice • Statements • Bills that are not itemized • Incomplete bills (missing information) • Cash register receipt from pharmacy • Incomplete receipt from pharmacy • Collection notices
Important Information The following is a list of some non-covered expenses	**Non-covered Expenses** • Treatment not directly related to the crime on which the claim is based • Over-the-counter items not prescribed by a treating physician • Mileage for court appearances • Hotel accommodations • Public transportation • Food items • Household items • Household utilities

Sexual Assault Program
Sexual Assault Forensic Medical Evidence Collection Examination
(Payment Procedure 'At A Glance')

IF: You are requesting payments for	THEN: You will need to provide
Sexual Assault Forensic Medical Examination **Sexual Assault (Acute) Protocol: Anonymous Reporting Protocol:** Criteria for payments: • The assault must have occurred in South Carolina Pursuant to South Carolina law which follows the guidance of the federal Violence Against Women Act statute, victims of assault in the State of South Carolina may request, at no cost to them, a forensic examination for sexual assault, regardless of their involvement with law enforcement. SOVA is the sole reimbursement provider for forensic examinations in South Carolina. Health Care Providers will bill SOVA directly for individual charges for lab work, emergency room fee, physician's fee, etc. Any fees beyond the actual collection of any evidence during a forensic examination will be the responsibility of the victim. Should law enforcement be involved, the option of SOVA victim compensation reimbursement becomes available.	Sexual Assault Forensic Medical Examination (Evidence collected within 120 hours of the assault) (18 and older) **Sexual Assault (Acute) Protocol: Anonymous Reporting Protocol:** Payment Requirements • SLED approved Sexual Assault Protocol kit must be used; • SOVA Sexual Assault Protocol (SAP) Billing Statement must be submitted; • SOVA Medical Examination Release Form must be submitted; • Payment requested within 180 days from the date of service. Important For Anonymous Reporting, SOVA Medical Examination Release Form must be submitted with the following information: • When providing law enforcement information, write in 'ANONYMOUS' instead of the name of the Law Enforcement Agency. • To establish that the crime happened in SC: the incident location (city/county and state) will be required. NOTE: Forms are located in the SLED approved kit.
Sexual Assault (Chronic) Protocol Criteria for payments: • The assault occurred in South Carolina • The assault was reported to law enforcement	Sexual Assault (Chronic) Protocol (Evidence collected after 72 hours of the assault) (17 and younger) Payment Requirements • Pages 1 and 2 of the Child Maltreatment Protocol billing statement; • Authorization and release form located in the Child Maltreatment Protocol ; • Law Enforcement Incident Report listing each child as a victim, the exam was ordered by law enforcement; and • Payment requested within 180 days from the date of service.
Forensic Interview Evidence Collection Protocol Criteria for payments: • The assault occurred in South Carolina • The assault was reported to law enforcement • The forensic interview was ordered by law enforcement Standards • The interview must be performed using standards defined by SOVA. • Interviewer must have a Masters level degree • Interviewer must have completed a 40 hour specialized forensic interview training and must be licensed • Interviews must be conducted at a facility that follows a multi-disciplinary model and has been approved by SOVA	Forensic Interview Evidence Collection Protocol (Interviews ordered by law enforcement for children 17 years old and younger) Payment Requirements • Billing invoice; • SOVA Forensic Interview Release Form; • SOVA Forensic Interview Report Form; and • Law Enforcement Incident Report listing each child as a victim • Payment requested within 180 days from the date of service

Helpful Hints for Providers:

SOVA assists victims of crime with out-of-pocket expenses, including crime-related Medical/Clinical/ Dental treatment. All claims or applications for assistance must meet the eligibility criteria prior to consideration with crime related compensable expenses.

If you are billing SOVA for the first time, before you submit a bill:	Providers will be required to provide a completed W-9 form: www.cg.state.sc.us/info/forms/payroll/substitute_W9.pdf **The following information will be required on the W-9:** • Legal Name as entered with IRS • Trade name • Remit address (where check should be mailed) • Entity designation (individual/sole proprietor, partnership, corporation) • SSN or EIN or TIN
Change in 'Remit' address(s)	• Providers such as hospitals will be required to provide SOVA with updated information on change of remit address or information on additional remit addresses. • If the provider's remit address changes, an updated W-9 will be required.
If you have been assigned a new tax identification number (TIN)	Providers who have been assigned a new taxpayer identification number (TIN) will be required to provide SOVA with updated information on a W-9 form.
New Owner of an existing business	For Sole Proprietors: if you are the new owner of an existing business, such as a Dentist Office or a Counseling Facility, and you have been assigned a taxpayer identification number, you will be required to provide an updated W-9 with the new TIN.
State Employees	Providers who are state employees and who are sole proprietors, such as counselors, will be required to complete a dual employment application
Unresolved Tax Issues/Tax Levy	Because SOVA is a state agency, providers who have unresolved tax issues might be required to resolve those issues before receiving payment from SOVA
Conflict with the IRS	A provider could be required to provide verification from the IRS confirming that your Employer Identification Number (EIN) (TIN) is active. Information regarding your (EIN) (TIN) can be obtained from the IRS. (For information on how to obtain information from the IRS about the status of your EIN, see information below) • 1-800-829-4933 (the EIN department), then • Select option 1 for English, then • Select option 1 for assistance, then • Request a 4158C, 147C or an EIN letter. Upon your request, you will receive a faxed cover sheet with the requested information and a letter will be sent to you from the IRS within 10 days. • And finally, you may fax the information to SOVA at (803) 734-2261. Pending payments will be mailed upon confirmation of your Employer Identification Number.

Helpful Hints for Providers (continued - PART II):

Documentation needed from Medical/Clinical/ Dental providers:	Upon filing a claim, victims/claimants are required to provide SOVA with medical/Dental claim forms. One of the following forms is required for all separate crime related dates of service. • **UB-04 Medical Claim Form** • UB-92 Medical Claim Form • Health Insurance Medical Claim Form (CMS-1500) (HCFA-1500) • Itemized bill of Charges • ADA Dental Claim Form (w/treatment plan) • Itemized bill from vision center and when applicable, • Health insurance information (EOB Explanation Of Benefit)
Documentation needed from Counselors:	• SOVA Mental Health Counselor's Report • Itemized bill of Charges w/CPT codes or, • Health Insurance Medical Claim Form (CMS/HCFA-1500) • Explanation of Benefits (EOB) for each date of service **Additional information could be required from Counselors/ Therapists:** • Diagnostic information • Session notes or date-specific session summaries • Counseling must be provided by a licensed professional (i.e. LCSW, LPC, LISW, PhD, or MD). SOVA CANNOT CONSIDER PAYMENT if medical claim forms, itemized billing information, and health insurance explanation of benefits statements (if applicable) have not been received.
Health insurance and EOBs	**If the patient has health insurance, including Medicare or Medicaid, insurance must be billed. SOVA cannot consider payment until other payment sources, including health insurance, have been exhausted. For insured victims/ claimants, SOVA must have a copy of relevant insurance explanation of benefits (EOB) statements for each crime-related date of service. These may be submitted by the victim/claimant or the medical provider; however, providers should note that submitting EOBs along with medical claim forms or itemized billing information is encouraged, as it may expedite claims processing and payment.**
Collections Activity: Section 16 3 1360: Collection activities prohibited	(A) When a person files a claim pursuant to this article, a health care provider that has received written notice of a pending claim is prohibited from all debt collection activities relating to medical and psychological treatment received by the person in connection with the claim until an award is made on the claim or the claim is determined to be non-compensable and is denied, or ninety days have passed after the health care provider first received notice of a pending claim. The statute of limitations for collection of the debt is suspended during the period in which the applicable health care provider is required to refrain from debt collection activities. (B) For purposes of this section, 'debt collection activities' means repeatedly calling or writing to the claimant and threatening to turn the matter over to a debt collection agency or to an attorney for collection, enforcement, or filing of other process. The term does not include routine billing or inquiries about the status of the claim." NOTE: If a victim/claimant has been placed in collections by a medical provider, the account should be removed from collections immediately upon notification that a SOVA claim is pending.

Helpful Hints for Providers (continued - PART III):

Negotiating Bills	Due to increased claims for uninsured victims of crime, SOVA is duty-bound to negotiate a reduction of payment on behalf of victims. The maximum award amount for eligible crime victims in the State of South Carolina is $15,000. Because most crime victims **do not have any health insurance (private or public) and owe multiple providers more than the maximum payable dollar amount,** SOVA request that providers accept negotiated payment/settlement agreements as payment in full for victims' outstanding crime related debt and not balance bill the victims.
Release of Information	Each victim/claimant who submits a signed application to the State Office of Victim Assistance (SOVA), for assistance, authorize the State Office of Victim Assistance (SOVA) to request, obtain, and release any information or records to determine the eligibility of compensable bills.
Payer of last resort status	The State Office of Victim Assistance is recognized as the payer of last resort, meaning that other **collateral resources**, restitution, subrogation, civil settlement, health insurance (public or private), and hospital charity care, when applicable, **must be exhausted before SOVA will consider payment.**
Payment is prohibited prior to services being rendered	South Carolina's guidelines **specifically prohibit payment prior to services being rendered.** SOVA can only consider payment after services have been rendered and after required documentation has been received.
Checking status of a claim/ payment	• Because SOVA's checks are dispersed by the State of South Carolina, it may take up to thirty days from the time the payment has been processed for a provider to receive a reimbursement check or electronic payment. • SOVA does not notify medical providers automatically of claim status (awards or denials). Award notifications are sent to the victim/ claimant, who has the responsibility to notify medical providers of the claim status. • Due to the high volume of telephone inquiries medical providers are encouraged to submit faxed request for payment status. Medical providers seeking claim/payment status may send a faxed request to (803) 734-1708. Status requests MUST include the victim's name, date of birth and Social Security Number. If the SOVA claim number is known, please include that as well. Please allow time for the file to be pulled and reviewed in order to respond to your request.
Under the Compensation & the Sexual Assault Program: **payments could be delayed for the following reasons:**	• Remit address was changed without notice • Remit address on the bill does not match information on W-9 • Billing name/name of facility does not match information on W-9 • Change in Tax Identification Number • Provider name change • Conflict with the IRS • Tax Levy • Dual employment

Helpful Hints for Providers (continued - PART IV):

Under the Sexual Assault Program: **Payments will be denied for the following reasons:**	• Missing law enforcement incident report for children 17 years of age or younger • The victim's name is not listed on the law enforcement incident report • Received past the 180 days filing deadline • Evidence collection protocol exam, for the crime date, has been paid • Victim's health insurance has paid • Follow up visits not covered • Chronic exam performed by someone other than a Physician, Nurse Practitioner, or SANE • Crime did not occur in SC
Maximum award limits:	Under the Compensation Program, all reimbursements are subtracted from the $15,000 maximum award amount. The victim may be eligible for additional financial assistance upon showing of a financial need. Under the Sexual Assault Program, SOVA reimburses from a fee schedule for evidence collection. For all medical treatment, as a direct result of physical injuries sustained during the assault, and for follow –up appointments, a victim compensation application will be required.

Mental Health Counseling Reimbursement

Notice: This section scheduled for revision 2012

DEFINITION

Mental health counseling for compensation purposes means "the assessment, diagnosis and treatment of an individual's mental and emotional functioning that is required to alleviate psychological trauma resulting from a compensable crime." This definition is in accordance with state statutes that afford reimbursement for medical expenses on behalf of eligible victims.

SUPPORTING DOCUMENTS REQUIRED

- **Mental Health Counselor's Report** form must be completed by the victim's counselor and must certify whether the psychological trauma being addressed is a direct result of the crime

- **Itemized bill in the victim's name** from the mental health counselor detailing the actual dates of service, type of service provided (i.e. individual, group, medication management), the CPT code assigned, and the amount charged

LICENSED PROFESSIONAL

SECTION 16-3-1180(A)(1) An award may be made for: reasonable and customary charges as periodically determined by the board for medical services, including mental health counseling, required and rendered as a direct result of the injury on which the claim is based, as long as these services are rendered by a licensed professional. Payment for mental health counseling is limited to the number of sessions during a one hundred eighty-day-period beginning on the date of the first counseling session or twenty sessions, whichever is greater. Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions;

Pursuant to 16-3-1180(A)(1) Effective January 2009: Upon recommendation of the director, the board may allow victims who max out the current benefit of twenty mental health counseling sessions to request up to an additional twenty sessions for a total of forty sessions. If a victim reached the maximum counseling benefits prior to January 2009, this does not apply.

REQUESTING ADDITIONAL COUNSELING SESSIONS:

- In compliance with the 20 session formula, after a claim is awarded and paid the maximum allowed for mental health counseling, the victim will be notified, in writing, of his/her right to be considered for additional counseling sessions, for a total of forty sessions, based on documented need.
- The victim must submit a written request for the additional counseling sessions.
- The request must contain information to justify extraordinary circumstances.
- The victim must submit supportive documentation from his/her treating clinician/counselor certifying that the additional sessions are directly related to the crime on which the claim is based.

- Provided that sufficient funds are available, the Director and the Advisory Board will determine whether the request is approved and will notify the victim when a decision is made.

NOTE: Financial assistance is limited to any number of sessions within 180 days of the first charged visit (up to the allowable recovery amount including other benefits) or 20 sessions scheduled as needed for resurfacing trauma, whichever is greater.

NOTE: SOVA pays the outstanding balance from bills not fully covered by existing medical insurance. If a victim has private or public medical insurance to include Medicaid/Medicare, bills must first be filed with applicable companies/carriers before submission to the agency for possible payment.

NOTE: Family sessions are reimbursed using the individual counseling fee scale.

NOTE: SOVA does not reimburse LMSW's practicing privately or independently for clinical services, including mental health counseling.

NOTE: Counseling sessions for offenders are not compensable under the Victim Compensation Program.

CPT Codes used by SOVA when Reimbursing/paying for counseling sessions	
90801	Initial session up to 2 hours: Psychiatric diagnostic interview examination
90804	½ session: individual face to face with patient: 20 - 30 minutes: individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility
90806	Full session: 45 - 50 minutes: individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility
90808	1 ½ session: 75 - 80 minutes: individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face-to-face with the patient
90847	Family psychotherapy (conjoint psychotherapy) with patient present)
90853	Group psychotherapy (other than a multiple family group)

CPT Codes used by SOVA when Reimbursing/paying for Med. Management	
90805	½ session: 30 minutes: with medication evaluation and management services
90807	Full session: 45 -50 minutes: with medical evaluation and management services
90862	Pharmacologic management, including prescription use and review of medication with no more than minimal medical psychotherapy

Reimbursement amount is based on a fixed fee scale:

Individual Counseling:
- LMSW, LPCI - $75.00/hr.
- Supervised PHD (Psychi/o) Candidate Interns - $75.00
- LPC, LCSW, LMFT & LISW - $90.00/hr.
- PHD Clinical Psychology - $105.00/hr.
- MD - $105.00/hr. (Include: medication management)

Group Counseling:
- LMSW, LPCI - $37.50/hr.
- Supervised PHD Candidate interns -$37.50/hr.
- LPC, LCSW, LMFT & LISW $45.00/hr.
- PHD Clinical Psychology -$52.50/hr.
- MD $52.50.00/hr. (include: medication management)

PART FOUR:

SAMPLE FORMS

SAMPLE FORMS

PROCESSABLE FORMS

SOVA accepts the following forms when considering payment/reimbursement:

UNPROCESSABLE FORMS

SOVA does not accept the following forms when considering payment/reimbursement:

- Final notices
- Statements
- Bills that are not itemized
- Incomplete bills (missing information)
- Cash register receipts from pharmacy
- Incomplete receipts from pharmacy
- Collection notices

Disclaimers:
Any information submitted on the forms is fictitious and intended for sample purposes only. Actual forms will reflect real data entered by providers. This site also includes forms from organizations other than SOVA and has been provided for sample purposes only.

The processable forms listed may change without notice and all submitted forms are subjected to verification, which may delay the process. SOVA may also require additional documentation.

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)

☐ Statement of Actual Services Ð OR Ð ☐ Request for Predetermination / Preauthorization

☐ EPSDT / Title XIX

2. Predetermination / Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Subscriber Identifier (SSN or ID#)
9. Plan/Group Number	10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other	

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Subscriber Identifier (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other	19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID / Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient / Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM / TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider Õs Office ☐ Hospital ☐ ECF ☐ Other	39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining	43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) / 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness / injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)	47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID	50. License Number	51. SSN or TIN

52. Phone Number ( ) Ð

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X _____
Signed (Treating Dentist) Date

54. Provider ID	55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) Ð	58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) Ð J516, J517, J518, J519

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTH DATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a					
	b					
	c					
	d					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	PAGE ____ OF ____	CREATION DATE			TOTALS		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A						
B						57 OTHER PRV ID
C						

58 INSURED 'S NAME	59 P. REL	60 INSURED 'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	QUAL
							LAST		FIRST
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL
							LAST		FIRST
							78 OTHER	NPI	QUAL
							LAST		FIRST
							79 OTHER	NPI	QUAL
							LAST		FIRST

80 REMARKS	81CC a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 FORM LDS9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ST1184.3 1PLY UB-92

County Hospital 551 West Street Anytown, IL 60066	2	3 PATIENT CONTROL NO. 7654321-001	4 TYPE OF BILL
5 FED TAX NO 37-7654123	6 STATEMENT COVERS PERIOD FROM 07-01-05	THROUGH 07-31-05	7 COV'D / 8 N-C'D / 9 C-I'D / 10 L-R'D / 11
12 PATIENT NAME Doe Child	13 PATIENT ADDRESS 1234 East Street, Anytown, IL 60066		

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
02-24-2004	F										

	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38 Doe Child
1234 East Street
Anytown, IL 60066

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		Physical Therapy	97110	071205	4	100. 00		
2		Physical Therapy	97110	071405	4	100. 00		
3		Physical Therapy	97110	072005	4	100. 00		
4		Physical Therapy	97110	072205	4	100. 00		
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23						400. 00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A						400. 00	POS - 11
B							
C							
57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Child		EI 155155		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
V571											

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE

82 ATTENDING PHYS. ID

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS
Therapist - Ann Therapist
Associate Level Provider - Peggy Associate

85 PROVIDER REPRESENTATIVE
X

86 DATE

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

SAMPLE MEDICAL CLAIM FORM

PICA ☐☐☐ PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __ 3. ____ . __

2. ____ . __ 4. ____ . __

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

Please read these instructions carefully before completing this form.

When to Use This Form

Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).

Natural or adoptive parents or a legal guardian, acting on behalf of a minor , who want us to release the minor's:

- nonmedical records, should use this form.
- medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

How to Complete This Form

This consent form must be completed and signed only by:

- the person to whom the information or record applies, or
- the parent or legal guardian of a minor to whom the nonmedical information applies, or
  the legal guardian of a legally incompetent adult to whom the information applies.

To complete this form:

- Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
- Fill in the name and address of the individual or group to which we will send the information.
- Fill in the reason you are requesting the information.
- Check the type(s) of information you want us to release.
- Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE : The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT : This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questionsSEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213. You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.

Form SSA-3288 (5-2007) EF (5-2007)

Form Approved
OMB No. 0960-0566

Social Security Administration

Consent for Release of Information

TO: Social Security Administration

_____ _____ _____

Name Date of Birth Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS

I want this information released because :

_____

_____

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _____ to _____
_____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
_____ Medical records
_____ Record(s) from my file (specify) _____
_____
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

Form SSA-3288 (5-2007) EF (5-2007)

SOVA: Certificate of Clinical Necessity

6/08

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 (803) 734-1900

Crime Victim Information:

Victim:_____ **Claim#:**_____

SS#:_____ **Crime Date:**_____

DOB:_____ **Crime Type:**_____

To the Treating Clinician: Providing the following information will not guarantee payment but it will be used to support the consideration for payment.

(1) In your professional opinion, do you certify with a reasonable degree of professional certainty that the □ **treatment or** □ **office visit** was reasonable, necessary and was directly related to the injury sustained during the crime?

Crime Date:_____ Type of Crime:_____ ☐Yes ☐No

(2) Diagnosis:

_____

_____

(3) Service Provided/Recommended Service: (Must include ICD-9 Codes/Procedure Codes)

ICD-9 Codes: _____ _____ _____

Procedure Codes: _____ _____ _____

_____

_____

_____

(4) Clinician's Statement of Justification: The treatment must be directly related to the above listed crime. (NOTE: This means that the crime must have either caused the injury or aggravated a pre-existing condition.)

_____

_____

_____

_____

_____

_____

(5) Expected Duration of Treatment _____Months

I certify that any statement hereto has been reviewed and signed by me. I certify that the information is true, accurate and complete, to the best of my knowledge.

Type or print Clinician's name_____ Phone:(___)_____

Clinician's Signature_____ Date:_____

Clinician's Address_____

SOVA: Certificate of Dental Necessity

6/08

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 (803) 734-1900

Crime Victim Information:

Victim:_____ **Claim#:**_____

SS#:_____ **Crime Date:**_____

DOB:_____ **Crime Type:**_____

To the Dentist: Providing the following information will not guarantee payment but it will be used to support the consideration for payment.

(1) In your professional opinion, do you certify with a reasonable degree of professional certainty that the □ **treatment or** □ **office visit** was reasonable, necessary and was directly related to the injury sustained during the crime?

Crime Date:_____ Type of Crime:_____ ☐Yes ☐No

(2) Diagnosis:

_____

_____

(3) Service Provided/Recommended Service: Must include tooth number(s), procedure code(s) and description(s)

_____

_____

_____

(4) Dentist's Statement of Justification: The treatment must be directly related to the above listed crime. (NOTE: This means that the crime must have either caused the injury or aggravated a pre-existing condition)

_____

_____

_____

_____

_____

_____

(5) Expected Duration of Treatment _____Months

I certify that any statement hereto has been reviewed and signed by me. I certify that the information is true, accurate and complete, to the best of my knowledge.

Type or print Dentist's name_____ Phone:(___)_____

Dentist's Signature_____ Date:_____

Dentist's Address_____

SOVA Mental Health Counselor's Report

Rev. 6/08

State Office of Victim Assistance ? 1205 Pendleton St., Brown Blg., Room 401, Columbia, SC 29201 ? Phone: (803) 734-1900 ? Fax: (803) 734-2261

Refer to instructions and stipulations on reverse side.

Today's Date ____/____/____

Victim's Legal Name _____ Claimant *(if a different person)* _____

Social Security No. ____/____/____ Crime Date ____/____/____

Is the trauma and the treatment a direct result of this crime? **YES** ____ **NO** ____

Presenting Complaint _____

Diagnosis of Record _____

Description of injury and/or psychological trauma as related to victimization _____

HEALTH INSURANCE CARRIER

Policy #

( )
Telephone No.

Company Name

Mailing Address or P.O. Box

City/State/Zip Code

Authorized Signature of Treating Therapist/Counselor

Printed Name of Payee

( )
Telephone No./Extension

License Type and No.

Mailing Address

City/State/Zip Code

Supervisor's Signature

License Type and No.

Date

NOTE: SOVA *does* NOT *act as guarantor for any services rendered.*

SOVA Employer's Report - Lost Wages / Support Rev. 1/10

State Office of Victim Assistance ? 1205 Pendleton St., Brown Blg. Room 401, Columbia, SC 29201 ? Phone: (803) 734-1900 ? Fax: (803) 734-2261

SOVA Claimant/Applicant filing for benefits *(print full name)* _____

Job Type _____ Social Security No. _____ /_____ / _____ Date of Birth _____ /_____ / _____

Employer: An application for assistance has been filed for the person listed above.
Please complete this form and return it to* SOVA *as soon as possible; a fax is acceptable.

Date the above person was first employed by you _____ /_____ / _____

Date he/she was first absent due to crime related injuries _____ /_____ / _____

Date he/she returned to work part time, if applicable _____ /_____ / _____

Date he/she returned to work full time _____ /_____ / _____

Date he/she was terminated, if no longer employed by you _____ /_____ / _____

Insurance Type and Policy No.

Health/Medical # _____ **Disability #** _____

Lost wages will be offset by other sources such as annual or sick leave, long/short term disability, SSA/SSI.

Was this employee compensated for time absent from work? _____ ***If so, how much?*** _____

Daily Work Schedule: from _____ ***am/pm to*** _____ ***am/pm***

Average work hours per week _____ ***Average overtime per week*** _____

Average hourly wage _____ ***Overtime hourly wage*** _____

Gross salary per week _____ ***Average commissions per week*** _____

Employer _____ Address _____ Phone No. (____)_____

Person Completing Form *(print)* _____ ***Signature***_____

Title _____ ***Date*** _____ ***Comments?***_____

**Further documentation may be required to receive lost wages/support, i.e., W-2, pay stubs, or tax returns. Wages will be offset by other sources such as annual or sick leave, social security or disability.
**Form must be faxed or mailed by employer.

SOVA Physician's Disability Report - Lost Wages Rev. 1/10

State Office of Victim Assistance ? 1205 Pendleton St., Brown Blg. Room 401, Columbia, SC 29201 ? Phone: (803) 734-1900 ? Fax: (803) 734-2261

An application for assistance has been filed with our office for the crime victim listed below. Please complete this form and return it to us as soon as possible; a fax is acceptable.

Full name of injured patient _____

Social Security No. _____ /_____ / _____ Date of Birth _____ /_____ / _____

Date the patient was first seen by you _____ /_____ / _____

Date of crime related injury _____ /_____ / _____ (must be completed)

Diagnosis:_____

_____

Briefly describe extent and location of injuries: _____

_____

Did the patient sustain any disability? Yes No (Please circle one.)

If yes, is the disability solely a result of this injury? Yes No (Please circle one.)
Please explain:_____

_____

Patient will be totally unable to work from _____/_____/_____ through _____/_____/_____

Has the patient been discharged from your care? Yes No (Please circle one.)

Has payment been filed with any of the following?

Medicaid	Yes	No	Policy #_____
Medicare	Yes	No	Policy #_____
Workers' Compensation	Yes	No	
Other insurance or program	Yes	No	Company or Agency _____
			Address _____
			_____

Type or print physician's name _____ Phone (_____)_____

Signature of physician_____ Date _____ /_____ / ____

Address of physician_____

**Form must be faxed or mailed by provider.

SOVA
South Carolina State Office of Victim Assistance
An Office of the Governor

State Office of Victim Assistance
Sexual Assault Protocol (SAP)
Billing Statement

Name (last, first, MI):_____ **SS#:** _____/_____/_____

DOB: _____/_____/_____ **Age:** _____ **Gender:** ☐ Male ☐ Female
Ethnicity: _____ **Race:** _____
Home Address: _____
City:_____ **State:** _____ **Zip Code:**_____
Name of Healthcare Provider: _____ **ACC#:**_____
Date of Service: (mm/dd/yy) ____/____/___

Laboratory Services

☐ **Gonorrhea Culture**
- ☐ Oral ($12)
- ☐ Rectal ($12)
- ☐ Vaginal ($12)

☐ **Chlamydia Culture**
- ☐ Oral ($35)
- ☐ Rectal ($35)
- ☐ Vaginal ($35)

- ☐ NAAT ($50)
- ☐ Herpes Culture ($20)
- ☐ Vaginal Culture ($20)
- ☐ Wet Prep/KOH Prep ($10)
- ☐ Serum Pregnancy Test ($25)

☐ **Gram Stain**
- ☐ Urethral ($10)
- ☐ Rectal ($10)
- ☐ Vaginal ($10)

- ☐ RPR, VDRL, Syphilis ($10)
- ☐ Presence of motile sperm ($5)
- ☐ Hepatitis B ($40)
- ☐ HIV HTLVI ($20)
- ☐ Urinalysis ($18)
- ☐ Blood Drawing Fee ($5)
- ☐ Urine Culture ($20)
- ☐ Urine Pregnancy Test ($20)

Medical Services

- ☐ Physician, FNP, NP Fee ($105)
- ☐ Emergency Room Fee ($75)
- ☐ SANE Fee ($80)
- ☐ Colposcopy Fee ($90)
- ☐ Clinic Fee ($50)
- ☐ Supplies ($12)

Medications

Medication	fee	Qty	Medication	fee	Qty
☐ Rocephine (Ceftriaxone) (injection)	$85 ea		☐ Plan B Levonorgestrel	$25 ea	
☐ Flagyl (Metronidazole) (tabs/ea)	$3 ea		☐ Ovral (Norgestrel) (tabs/each)	$1.75 ea	
☐ Phenergen (Promethazine) (tabs/ea)	$2.20 ea		☐ Zithromax (Azithromycin) (tabs/ea)	$10 ea	
☐ Phenergen (suppository 50mg ea)	$12.74 ea		☐ Lidocaine	$21 ea	
☐ Suprax (Cefixime) (tabs/ea)	$11.25 ea		☐ Tetanus	$21 ea	
☐ Cipro (Ciprofloxin) (tabs/ea)	$8.00 ea		☐ Other (specify)_____		
☐ Doxycycline (tabs/ea)	$2.64 ea				
☐ Hepatitis B vaccine	$21.00 ea				

Total Amount Billed

$_____

Please Remit Payment To:

Fed Tax#_____

Health Care Provider must attach a copy of **the Medical Examination Release Form (located in the SLED approved protocol kit) to this Protocol Billing Statement** for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, SC 29201

State of South Carolina
State Office of Victim Assistance
Medical Examination Release Form

In the matter of:

Patient	Name of Health Care Provider
Social Security Number	Federal Tax Number
Address	Address
City State Zip	City State Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance (SOVA) and its authorized agents to receive my medical records. I also authorize SOVA to pay such medical expenses allowed by law to Health Care Providers for routine medical tests and examinations for evidentiary purposes as prescribed by South Carolina Law Enforcement Division (SLED)/South Carolina Hospital Association sexual assault protocol kit.

Dated this _____ day of _____ , 20_____, at

_____, South Carolina.

Signature of Patient/Guardian/Responsible Adult	Health Care Official's Signature (SANE/MD)

Print Name of Law Enforcement Officer — Signature of Law Enforcement Officer

Name of Law Enforcement Agency (Do not abbreviate) – For anonymous reporting: write in **"Anonymous"**

Incident Location (County and State) — Date of Crime

Health Care Provider must attach a copy of **SOVA Sexual Assault Protocol (SAP) Billing Statement (located in the SLED approved protocol kit) to this Medical Examination Release Form** for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street, Rm. 401
Columbia, South Carolina 29201
Phone: (803)734-1900

Revised February 2010

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 (803) 734-1900

Today's Date _____

Victim's Legal Name:_____

Age:_____ Date of Birth:_____ Gender_____ Race_____

Was forensic interview done as a part of an investigation of an alleged crime? Yes____No___

Type of Allegation:
- Physical Assault_____
- Sexual Assault_____

Outcome of Forensic Interview
- No disclosure _____
- Disclosure of assault _____
- Problematic disclosure _____
- Recantation of prior disclosure _____
- Forensic assessment not completed _____reason?___
- _____

Professional Opinion: Was allegation a result of a crime? Yes___ No___

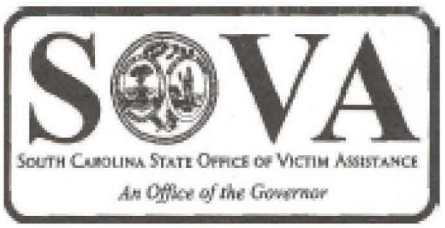
Location of Crime: _____
City/County State

Basis of Professional Opinion: (What happened; where; who; when, if possible)

Name/Title of Interviewer _____
Interviewer License # _____Type_____
Or Supervisor name and license #_____
Date/Place of Interview _____
Law Enforcement Jurisdiction_____

The Children's Advocacy Center must attach a copy of **the Forensic Interview Billing Statement**, **the Forensic Interview Release Form and a law enforcement incident/supplemental report to this Forensic Interview Report** for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201



State of South Carolina
State Office of Victim Assistance
Forensic Interview Release Form

In the matter of:

_____	_____
Patient	Name of Forensic Interviewer
_____	_____
Social Security Number	Name of Children's Advocacy Center
_____	_____
Address	Address
_____	_____
City State Zip	City State Zip

In accordance with South Carolina Victims and Witnesses Bill of Rights, signed into law on June 22, 1984, I hereby voluntarily consent and authorize the South Carolina State Office of Victim Assistance and its authorized agents to receive my interview records and to pay directly such expenses allowed by law to the Children's Advocacy Center for the forensic interview conducted for evidentiary purposes as prescribed by South Carolina State Office of Victim Assistance.

Dated this _____ day of _____ , 20_____, at

_____	_____
Signature of Patient/Guardian/Responsible Adult	Forensic Interviewer's Signature

_____
Name of Law Enforcement Officer

_____
Signature of Law Enforcement Officer

_____
Name of Law Enforcement Agency

The Children's Advocacy Center must attach a copy of the Forensic Interview Billing Statement, the Forensic Interview Report, and a law enforcement incident/supplemental report to this Forensic Interview Release Form for payment and forward to:

STATE OFFICE OF VICTIM ASSISTANCE
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201
Phone: (803)734-1900

SOVA: Forensic Interview Billing Statement 2/2011

State Office of Victim Assistance 1205 Pendleton St., Brown Bldg., Room 401, Columbia, SC 29201 (803) 734-1900

Invoice Date: _____ Invoice # _____
Date of Service: _____

Victim's Legal Name:_____
Date of Birth:_____ SS#:_____ Crime Date:_____
Was this interview requested by Law Enforcement? _____yes _____no

Remit payment to:

Tax ID Number: Telephone Number:

Total Charge $175.00

Name/Title of Interviewer _____

The Children's Advocacy Center must attach a copy of **the Forensic Interview Report, the Forensic Interview Release Form, and a law enforcement incident/supplemental report to this Forensic Interview billing statement** for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar A. Brown Building, Room 401
Columbia, South Carolina 29201

SOVA
South Carolina State Office of Victim Assistance
An Office of the Governor

South Carolina Children's Advocacy Medical Response System

Child Maltreatment Protocol Billing Statement

Child's Name (last, first, MI) :			**SSN:**
Date of Birth (mm/dd/yy):	**Age:**	**Gender**	☐ Male ☐ Female

Race
☐ American Indian/Alaska Native ☐ Black/African American ☐ Pacific Islander
☐ Asian ☐ Multiracial ☐ White/Caucasian
☐ Biracial ☐ Other: *Specify*

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Other: *Specify*

Account Number:	**Date of Crime (mm/dd/yy):**
Facility Name:	**Telephone Number:** ( ) -

Place of Incident: **County:** **State:**

Law Enforcement Agency (do not abbreviate):	**Case Number:**

Evaluation For (check all that apply)

☐ Drug Endangered Child	☐ Pediatric Condition Falsification	☐ Threat of Harm
☐ Failure to Thrive	☐ Physical Abuse	☐ Physical Abuse
☐ Neglect	☐ Sexual Abuse	☐ Sexual Abuse
Specify:	☐ Other: *Specify*	

Other Miscellaneous Injuries

☐ Burns	☐ Fractures	☐ Lacerations/Wounds
☐ Contusions/Bruises	☐ Head/Scalp Injuries	☐ Scars
☐ Other: *Specify*		

Healthcare Provider Signature: **Date:**

Healthcare provider and/or facility **must attach a copy of the Law Enforcement Incident Report** and **Authorization and Release Form** to this billing statement for payment and forward to:

State Office of Victim Assistance
1205 Pendleton Street
Edgar Brown Building, Room 401
Columbia, SC 29201

SOVA
South Carolina State Office of Victim Assistance
An Office of the Governor

South Carolina Children's Advocacy Medical Response System

Child Maltreatment Protocol Billing Statement Supplement

Child's Name (last, first, MI) :

DOB (mm/dd/yy):

Date of Evaluation (mm/dd/yy):

Medical Services

- ☐ Healthcare Provider Fee ($105)
- ☐ Clinic Fee ($50)
- ☐ Emergency Room Fee ($75)

Procedures

- ☐ Colposcopy Fee ($90)

Miscellaneous Fees

- ☐ Supplies ($12)

Laboratory Services

- ☐ Gonorrhea Culture
  - ☐ Oral ($12)
  - ☐ Rectal ($12)
  - ☐ Vaginal ($12)
- ☐ Chlamydia Culture
  - ☐ Rectal ($35)
  - ☐ Vaginal ($35)
- ☐ NAAT ($50)
- ☐ Trichomonas Vaginalis Culture ($35)
- ☐ Herpes Simplex Culture ($20)
- ☐ Vaginal Culture ($20)
- ☐ Wet Prep/ KOH Prep ($10)
- ☐ GramStain
  - ☐ Urethral ($10)
  - ☐ Vaginal ($10)
- ☐ RPR, VDRL, Syphilis ($10)
- ☐ Hepatitis B ($40)
- ☐ HIV by Elisa ($20)
- ☐ B-HCG, Blood ($25)
- ☐ Urinalysis ($18)
- ☐ Urine Culture & Sensitivity ($20)
- ☐ Urine Pregnancy Test ($20)
- ☐ Urine Drug Screen ($50)
- ☐ CBC ($35)
- ☐ Platelet Count ($20)
- ☐ SMA - Basic Metabolic Panel ($27)
- ☐ Liver Function Test ($59)
- ☐ Amylase ($22)
- ☐ PT & aPTT ($40)
- ☐ Fibrinogen ($37.50)
- ☐ von Willebrand Antigen ($126)
- ☐ Ristocetin Cofactor ($56)
- ☐ Blood Drawing Fee ($5)

Radiographs/ Imaging Studies

- ☐ Skeletal Survey Complete ($140)
- ☐ Skull - 4 Views ($80)
- ☐ Chest PA & Lateral ($29)
- ☐ Humerus ($55)
- ☐ Forearm ($25)
- ☐ Hand - Minimum 3 Views ($52)
- ☐ Pelvis AP ($75)
- ☐ Pelvis & Hips - Infant ($90)
- ☐ Femur ($25)
- ☐ Tibia Lower Leg ($25)
- ☐ Cervical Spine ($90)
- ☐ Spine Entire AP LAT ($275)
- ☐ Lumbar Spine ($95)
- ☐ Thoracic Spine ($90)
- ☐ CAT Scan ($500) Head
- ☐ CAT Scan ($500) Abdomen

Total Amount Billed $

Please remit payment to:

Tax ID Number:

Healthcare provider and/or facility must attach a copy of the **Law Enforcement Incident Report/Supplemental Report**, **Authorization and Release Form**, along with pages 1 and 2 of this **Child Maltreatment Protocol Billing Statement** for payment.

AUTHORIZATION AND RELEASE

I authorize _____ to release medical information
Facility Name

related to this incident to:

- ☐ State Office of Victim Assistance (SOVA)
- ☐ Department of Social Services
- ☐ Law Enforcement
- ☐ Solicitor
- ☐ Guardian ad Litem
- ☐ SC Children's Advocacy Medical Response System

and hold harmless this facility and its staff, from any and all liability and claims of injury which may in any manner result from the release of such information.

I also authorize the release of medical information to:

- ☐ Private Physician
- ☐ Mental Healthcare Provider
- ☐ Other *Specify* _____

for the continuing diagnosis and treatment of this child.

I request and authorize the State Office of Victim's Assistance (SOVA) to assign the payment for medical services provided on this child's behalf to:

Facility Name _____

Address _____

City _____ State _____ Zip Code _____

I permit a copy of this authorization to be used. I understand that I have the right to withdraw this authorization at any time by notifying this facility in writing. I understand that the withdrawal is not effective for any actions taken prior to this withdrawal. Without a written notice to withdraw this authorization, it will expire 1 year from the date the medical service is provided.

Child's Name: _____ Date of Birth: _____ SSN: _____

Address: _____

Contact Phone Number _____

By signing, I consent to the authorization and release of medical information of the named child as described above.

_____ _____ Date: _____
Signature of Parent/Legal Representative Printed Name

_____ _____ Date: _____
Signature of Parent/Legal Representative Printed Name

_____ _____ Date: _____
Signature of Witness Printed Name

State of South Carolina
Comptroller General's Office
(9/07)

Vendor Administrator

Substitute **W-9**

DO NOT send to IRS

Taxpayer Identification Number (TIN) Verification

Print or Type
Please see attachment or reverse for complete instructions

Legal Name (as entered with IRS) If Sole Proprietorship enter your Last, First, MII	Entity Designation (check only one) ***Required*** ☐ Individual / Sole Proprietor ☐ Partnership ☐ Corporation (includes service corporations) ☐ Limited Liability Company – Partnership ☐ Limited Liability Company – Corporation ☐ Governmental or Tax Exempt Entities (specify, e.g. 501(c) (3), etc.)
Trade Name If doing business as (DBA) or enter business name of Sole Proprietorship	
Order Address (where orders should be mailed) PO Box or Number and Street, City, State, Zip + 4	Taxpayer Identification Number (TIN) If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, using you EIN may result in unnecessary notices to the requestor. ***Required*** ___ ___ ___ ___ ___ ___ ___ ___ ___
Remit Address (where checks should be mailed, if different from Order Address) PO Box or number and street, City, State, Zip + 4	Check Only One ***Required*** ☐ Social Security Number (SSN) ☐ Employer Identification Number (EIN) ☐ Individual Taxpayer Identification Number for U.S. Resident Aliens (ITIN)

Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number, AND
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I am a U.S. person (including a US resident alien).

Printed Name	Printed Title	Telephone Number ( )
Signature		Date